What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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SWIMMING AGAINST THE TIDE

The call for "community participation" to solve problems is far from unique. Nevertheless, examples and techniques for achieving this in practical terms are uncommon. The Navrongo Health Research Centre's (NHRC) health and family planning initiatives confront a challenging context; significant institutional, economic, social, health and environmental concerns of community members must be addressed if programmatic efforts are to succeed. In keeping with the central import of community participation, the NHRC, from the outset, initiated an assessment of obstacles to programme creation in response to these constraints. Through qualitative studies on fertility norms, behavior, and beliefs, the advice of community members was used to identify and catalogue specific operational constraints and to provide culturally appropriate response strategies to them. The following were identified early in the Phase I pilot programme.

Environmental Constraints

Settlement patterns. The population of Kassena-Nankana is both isolated and dispersed. Clinics are underutilized and public transportation is poor; consequently, Community Health Nurses (CHN) were installed and provided with motorbikes. Community leaders recommended that the bases of operation of CHN could be relocated effectively if assisted by the Chiefs and a community liaison officer. By charging communities with the construction of compounds for the CHN, the project elicited their involvement and support.

Seasonality. Fertility, mortality, and general adversity vary with the seasons in these agrarian communities. Strategic planning calls for a focus on family planning in durbars during peak conception periods, a focus in wet seasons, etc. Further, family planning service hours, cost, and location must be flexible and vary with the harvest season dry seasons[1].

Community durbar

Sociocultural Constraints

The role of tradition. In this traditional rural society, the strength of central bureaucracy is surmounted by strong community leadership by Chiefs and Councils of Elders. Traditional leaders, then, must be consulted and involved in programme planning, and local institutions must be employed. For example, the programme can benefit from the *Zurugelu* system of traditional action committees and community durbars, which are usually scheduled on market days for maximum attendance and impact.

If my husband marries a second woman and he does not want us to do (family planning) and she doesn't do it, he will love her; he will not love me again. If he has something small, he will give it to her and leave me...In the night I will be sleeping alone with all my family planning...

Young Naga woman

Gender roles. In the discussions during village durbars, men demonstrated little understanding of, and interest in, family planning. Married men often are apprehensive about this outside influence on reproductive behavior. Women's access to contraceptives is limited as they may be forbidden to travel for services or may lack reproductive autonomy. An assurance of confidentiality as well as open discussions, as in durbars, may increase information about, acceptance of, and trust in family planning services. Men can be targeted through a *Zurugelu* programme for Chiefs, elders, and husbands while women may benefit from IE&C activities addressing appropriate responses to husbands and kin who do not support contraceptive use.

[1] Research has shown that fertility in the Kassena-Nankana District is highly seasonal. The period immediately following the harvest is the peak conception season. Appiah-Yeboah Shirley et al. 2001 "Impact of Agricultural Adversity on Fertility among the Kassena-Nankana of Northern Ghana"

Religion and pronatalist traditions. Soothsayers, who are influential members of the community, are likely to oppose family planning programmes. Consequently, the survey suggests that soothsayers be consulted about specific strategies and that respected traditional community leaders be involved in the promotion of family planning services.

The nature of demand. Demand for family planning is complex and contradictory in some respects. Women cite large families as ideal, yet express a desire to limit their fertility. The current term for family planning services *adog-maake,* which translates to "stopping childbearing," further complicating the apparent intentions of programmes. Spacing childbirth is, however, well understood. Health workers must be retrained in outreach strategy and in ways to conceptually link primary health care and family planning. Candid doorstep conversations, rather than simple woman-to-woman transmission of information, may foster broader and longer-term changes in attitudes.

Economic Constraints

Extreme poverty. In an environment in which resources are scarce to find, women are compelled to turn to their husbands and family relations to pay for even things such as contraceptives. Under such circumstances, lowering the price of contraceptives does not eliminate financial barriers to access. Cost-sharing schemes and coupons may therefore be more effective at increasing family planning use. Children represent economic value; however, families increasingly favor wage earning over farm labor. Programmes may generate demand by establishing credibility and emphasizing links to child survival.

Agrarian economy. Cash, long-range service delivery, and exposure to mass media are all limited. Music and cultural events communicating family planning and other health themes may therefore be most effective. Family planning programmes may benefit from traditional networks such as men's cooperatives for harvesting and *Susu*, women's associations for trade, marketing, and lending, both in terms of information dissemination and in terms of employing existing means of sharing adversity.

Consultation with traditional healers works, confrontation fails

Basic health care concerns. Mortality and morbidity indicators and rates of infectious diseases are high in Kassena-Nankana District, and given limited resources and energy, family planning programmes must show their own importance. These circumstances call for a shift from the needs of bureaucracies, statisticians, and demographers towards those of the community. Durbars may therefore include discussions of sanitation, immunization, and common diseases in conjunction with family planning information and services.

Faith in traditional medicine. Belief in traditional healers and soothsayers' advice often causes delays in seeking allopathic and nontraditional opinions. These traditional healers must be consulted about the formation and structures of proposed interventions.

Reproductive health and delivery problems. Given the prevalence of reproductive health problems and the high incidence of labor complications, an efficient referral system must be put in place and community health workers trained to screen and refer patients when the need arises.

Conclusion

From an assessment of these problems, the Navrongo staff proceeded to investigate what service delivery, community health education, and outreach strategies could be designed to optimally address them. Each problem was aligned with a proposed solution; each solution was tested in a micro-pilot, and focus groups were convened to gauge community reactions and to seek advice on ways to move forward. In this manner, social learning, listening, testing, and responding over time, became a resource for organizing the Community Health and Family Planning Project.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made the *Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.